

A Report on the Post-September 11 State Disaster Relief Grant Program of SAMHSA's Center for Substance Abuse Treatment



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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Division of State and Community Assistance, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857

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Introduction

The events of September 11, 2001, caused unprecedented loss of human life and physical destruction. The Federal government provided immediate disaster assistance to New York, Virginia, and Pennsylvania to aid in the physical recovery and security of those communities in which the attacks occurred. In many respects, the immediate images of catastrophic loss of life and physical destruction overshadowed the devastating psychological effects of the disaster that continue years after September 11. States reported an increased demand for substance abuse treatment and mental health services that they could not meet with existing financial resources.

To help communities meet those increased mental health and substance abuse service needs in a post-September 11 world, the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U. S. Department of Health and Human Services, allocated \$28 million in grants to the nine States most directly affected by the terrorist attacks—Connecticut, the District of Columbia, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, and Virginia. These grants were awarded to help ensure the provision of substance abuse and mental health assessment and treatment services as long as a need remained for these services among individuals and communities directly affected by the September 11 disasters.

The release of grant funds by SAMHSA to the nine States most directly affected by the terrorist attacks occurred in two phases. In Phase I, beginning on October 1, 2001, SAMHSA made available \$6.8 million to the nine States to conduct needs assessments that would identify gaps in service capacity and to support hotline crisis response systems. In Phase II, beginning on October 29, 2001, SAMHSA made grants available to the same States for substance abuse and mental health planning, training, and service needs that arose as a result of September 11. SAMHSA encouraged States to use a portion of the allotted funds to accommodate the support and recovery needs of children and adolescents following the attacks. States received funds through one or more of SAMHSA's three centers: the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS).

This report focuses on the program activities undertaken by the nine States that received CSAT grants under the Post-September 11 State Disaster Relief Grant Program. The funding allocation for the nine recipients of CSAT's disaster relief grants was:

Connecticut: \$1,100,000;

District of Columbia: \$937,000;

Maryland: \$475,000;

Massachusetts: \$575,000;

New Jersey: \$1,622,372;

New York: \$3,700,000;

Pennsylvania: \$962,500;

Rhode Island: \$150,000; and

Virginia: \$395,547.

Just over two years after making these awards, CSAT convened a meeting of the nine State recipients to share State objectives, activities, products, and lessons learned through the grant program. The information obtained at this February 25, 2004, meeting was combined with data gathered from each State's interim and final reports. This process yielded a comprehensive picture of the accomplishments and challenges of each State as it planned and implemented grant-supported activities. Several States reported that SAMHSA was the only Federal agency that provided immediate disaster response assistance to address substance abuse and mental health concerns. They noted that, without the grants from CSAT, many of their achievements would not have been possible.

The report has two main sections:

Crosscutting themes for States participating in CSAT's Post-September 11 Disaster Relief Grant Program. This section details common objectives, activities, products,

lessons learned, and future directions that several States initiated through the grant program.

State-specific observations from participating States. This section identifies State-specific activities and lessons learned that were not discussed in the crosscutting themes section.

This report provides an overview of the contributions of Single State Authorities for Alcohol and Substance Abuse Services with respect to disaster planning, training, and service provision for the field of substance abuse treatment. The concluding section of the report also makes several suggestions for additional technical assistance to build on the work of the CSAT grantees.

Crosscutting Themes for States Participating in CSAT's Post-September 11 Disaster Relief Grant Program

From the perspective of all nine States, the terrorist attacks had several effects:

They reinforced the needs for State agencies to establish disaster preparedness plans for the substance abuse treatment system.

They affected the substance abuse prevention and treatment systems by:

- Increasing the intensity and need for service intervention for *individuals and families currently involved* in substance abuse treatment and prevention.
- Increasing a return to services for *individuals and families who previously had received* substance abuse services; and
- Increasing the use of alcohol, tobacco, and other prescription and nonprescription medications in the aftermath of the attacks by *people who may not have used these substances previously*.

Several of the States participating in CSAT's Post-September 11 Disaster Relief Grant Program used their funds in similar ways to achieve program goals and objectives. Common objectives, activities, products, lessons learned, and future directions among these States are described below. A concise table of crosscutting themes for States is presented in the Appendix.

Common Objectives

Common objectives of participating States can be classified into three main categories: (1) infrastructure development, (2) provision of specialized services, and (3) training for providers. Six States (CT, DC, MD, NJ, NY, RI) planned to enhance preparedness for future disasters through infrastructure development, including the creation of disaster preparedness plans that explicitly identified and clarified the role of the substance abuse delivery system. Connecticut reported it planned to form collaborations with providers and other State agencies to develop unified and coordinated disaster response protocols. Maryland focused its efforts on developing a system to transfer client information from one central contact point to direct service providers during a crisis. Two States with comparatively high numbers of residents who had lost loved ones on September 11, New York and New Jersey, made a priority of expanding and enhancing hotline services to assist individuals with immediate substance use and mental health issues. Rhode Island developed a behavioral health disaster response network composed of regional teams of substance abuse and mental health providers representing all geographic areas of the State. Headed by community-based behavioral health centers, these teams were trained in critical incident response and stress management.

Eight of the nine States (CT, DC, MA, NJ, NY, PA, RI, VA) designed their key objectives around the provision of specialized services to individuals and communities most directly affected by the events of September 11, with a specialized focus on substance abuse. Five of them (CT, DC, MA, RI, VA) reported objectives of serving children and adolescents, including outreach and programs in schools. Connecticut's objective was to provide outreach to and relapse prevention services for the recovery community. As the site of the World Trade Center attacks, New York faced many challenges in providing substance abuse education, outreach, and referral services. It worked to provide services to union members and their families who were directly affected by the World Trade Center attacks, maintain substance abuse service delivery based on the needs of communities, and conduct outreach and provide links to appropriate services in the communities most affected by the attacks. New York chose to work through labor unions because their already established extensive network of communication enabled the State to reach large numbers of affected workers to inform them about the potential for substance use and to provide supportive services.

Four States (CT, NJ, NY, PA) cited the objective of providing training to substance abuse treatment providers in disaster response. These States recognized the need to strengthen the skills and abilities of providers to respond to increased service needs in an emergency and the need to train providers in self-care strategies to prevent them from being overwhelmed by the traumas.

Common Activities

The nine States participating in the grant program conducted a range of activities designed to assist State agencies and providers in a disaster or emergency: (1) performing needs assessments; (2) fostering collaboration for disaster preparedness; (3) providing specialized substance abuse treatment services and outreach; (4) providing various types of training; and (5) offering public education.

Performing Needs Assessments

All needs assessments identified an increased use of alcohol, tobacco, and prescription medication following the attacks. A portion of this increase was attributed to individuals who were substance users prior to the attacks and who subsequently sought clinical intervention. Variables that affected increased substance use included prior trauma, proximity to the physical disaster, pre-existing mental conditions, and insufficient social support networks.

Six States (DC, MA, NY, PA, RI, VA) used their grant funds to conduct needs assessments of the impact of September 11 on individuals and communities. Massachusetts, New York, and Virginia included schools in their needs assessments to help determine the impact of September 11 on school-age children and the needs of schools to cope with the effects of the attacks. New York's Statewide needs assessment strategy included the collection of data through a host of activities: a literature review, street ethnography, provider focus groups, household surveys, indicator trends, and treatment utilization records. In the months following the disaster, Pennsylvania conducted county surveys to assess the continued need for funds to serve clients affected by September 11. Rhode Island conducted key informant interviews and focus groups to investigate perceptions of system capacity before and after September 11. Most of the States that conducted needs assessments are in the final stages of completing their reports and will share the final reports, once complete.

One of the District of Columbia's main objectives was to conduct a comprehensive needs assessment to determine the impact on mental health and substance abuse treatment providers of September 11 and the anthrax attacks. The District of Columbia sought to identify gaps in the treatment system and interruptions in service delivery that should be addressed. Major findings indicated that the health care system in the District of Columbia as a whole had difficulty in providing services during the attacks, largely since no formal disaster plans clarified staff roles and responsibilities. In terms of individual service needs, 81% of clients in D.C. reported experiencing anxiety, depression, and unemployment as a result of the disasters. The needs assessment found that the service capacity in the City in general was insufficient to accommodate increased admissions due to the disasters, particularly in the area of services for substance-abusing youth. The City structured its grant activities to respond to the concerns identified in the needs assessment.

Fostering Collaboration for Disaster Preparedness

Several of the nine participating States conducted activities designed to foster collaboration among various local providers, State agencies, recovery communities, and other stakeholders in disaster preparedness. States realized that to have disaster response plans implemented successfully, all stakeholders must be involved in response development. States undertook two main activities related to fostering collaboration for disaster preparedness: (1) development of networks for disaster response planning that included substance abuse providers, and (2) creation of disaster preparedness plans.

Five States (CT, MA, DC, NJ, RI) participated in the development of community networks for disaster preparedness activities.

Connecticut developed a substance abuse disaster response model combining the public and private substance abuse and mental health leadership in the State. This network of "crisis partners" included treatment and prevention providers, persons in recovery, the faith community, Yale University, the University of Connecticut, and several State agencies. Members of this group created the Center for Trauma Response, Recovery and Preparedness (CTRP) to develop "behavioral health response team networks" in several communities Statewide to deal with future emergencies and disasters. Since its inception

in December 2001, CTRP has provided training and technical assistance to substance abuse providers, persons in recovery, emergency first responders, police and fire personnel, school systems, clergy, and other community groups.

Massachusetts restructured its Disaster Mental Health Committee to include stakeholders in substance abuse services. The State renamed the group the Disaster Mental Health and Substance Abuse Services Committee to give appropriate consideration to substance use issues that can occur following a disaster.

The *District of Columbia* convened an emergency preparedness planning team that included substance abuse professionals.

New Jersey solicited and approved 33 substance abuse providers for its World Trade Center: New Jersey Recovers treatment network.

Rhode Island developed seven regional response teams composed of a core of trained leaders and staff from the community mental health centers, a clergy representative, and representatives from State-licensed substance abuse and mental health treatment organizations. A Department Advisory Crisis Management Task Force, composed of representatives from other State departments, provider organizations, the American Red Cross, and professional organizations, also was established.

Four States (CT, DC, MA, RI) dedicated significant effort to develop and/or revise disaster plans to include substance abuse and to prepare for future emergencies. Connecticut developed a Statewide crisis response plan; and public health agencies in Massachusetts revised the health and medical services section of the State's Comprehensive Emergency Management Plan, including substance abuse issues. Rhode Island revised its Behavioral Health Disaster Response Plan to clarify the roles and responsibilities of various parties, including the development of job descriptions to be used by staff, should they be required to assume a different role in the event of an emergency. Finally, the District of Columbia developed and revised an All-Hazards Emergency Preparedness Response Plan and adjusted its contractual agreements to require individual providers (including substance abuse providers) to submit emergency response plans.

Providing Specialized Substance Abuse Treatment Services and Outreach

All nine States were committed to providing specialized substance abuse treatment services and outreach to individuals and communities directly affected by the events of September 11.

Several of the States offered substance abuse treatment services and outreach to specific target populations, such as children and first responders, and almost all States included access to hotlines as part of their efforts to meet the increased demand for mental health and substance abuse services following a disaster.

Direct Substance Abuse Treatment Services. Seven States (CT, DC, NJ, NY, PA, RI, VA) used their grant funds to provide specialized substance abuse treatment services to individuals and communities directly affected by the events of September 11. These States offered a variety of services, including assessment, treatment placement, individual counseling, group therapy, and aftercare. Specifically, the District of Columbia provided case management, aftercare, and wraparound services, and developed a network of substance abuse treatment providers to provide a seamless continuum of care for adolescents. One-third of New Jersey's individuals who received substance abuse treatment services with CSAT funds were adolescents. Virginia used a portion of its funds to provide detoxification for children and adolescents whose need for services was identified following the disaster.

Four States (CT, NY, RI, VA) offered targeted substance abuse treatment services to specific populations, including homeless individuals; first responders; individuals receiving methadone treatment; individuals in recovery; and Asian, Hispanic, African American, and American Indian populations. New York provided critical-incident debriefing and increased workplace services to union members and their families who were directly impacted by the World Trade Center attacks. Virginia designed interventions for first responders to the Pentagon attack and for professionals who assisted these first responders immediately following the disaster. In response to an anticipated large number of Spanish-speaking clients, Rhode Island scheduled an interpreter to be with the clinicians at a community health center every week.

A main component of Connecticut's efforts was the development of specialized services and support for the recovery community. Activities included three recovery events at which individuals could receive information on risks to recovery related to September 11 and resources available to help cope with the disaster. Substance abuse treatment professionals received

specialized training on issues related to trauma, and clinical support services for interested individuals also were made available. Twelve local chapter meetings of a recovery organization were organized and designed to share resources for trauma for those in recover from substance dependence. Four of the organization's public access television shows focused on substance abuse and the trauma of September 11 and provided sources for help and information.

Hotlines. As part of the effort to meet the service needs of communities following the events of September 11, several States (CT, DC, MA, MD, NJ, NY, PA, VA) took part in the creation, expansion, or enhancement of hotline services and capabilities.

The District of Columbia established a hotline after September 11 for substance abuse and mental health services personnel. The hotline offered information and referrals 24 hours a day, 7 days a week.

Massachusetts assisted in the development of an information line for the mental health and substance abuse implications of disasters and terrorism. The hotline was available 24 hours a day, 7 days a week.

New Jersey used its existing addiction hotline to provide crisis debriefing 24 hours a day, 7 days a week to World Trade Center survivors, rescue workers, in-person witnesses, individuals left unemployed by the attacks, and their families. The State also electronically linked the hotline to the National Council of Alcoholism and Drug Dependence (NCADD) so callers could be transferred directly to NCADD's counselors. The State coordinated with the hotline to ensure that individuals calling for assistance would obtain an initial appointment within 24 hours of their call.

New York expanded the hours for a Statewide substance abuse information line that provided referrals, crisis counseling, and employment assistance to individuals. The State also hired staff proficient in Spanish for the information line. Since September 11, the volume of calls to the substance abuse information line has increased by over 80%.

Maryland focused on infrastructure development to allow the real-time capture of its crisis hotline data to assist in the allocation of substance abuse and mental health resources during emergencies.

Virginia implemented a State hotline for people to be connected with local substance abuse service providers.

Connecticut used a “211” hotline number to provide assistance and referrals to individuals who identified a need for mental health and/or substance abuse services.

Outreach Initiatives. Six States (CT, MA, NJ, NY, RI, VA) conducted specific substance abuse outreach initiatives to culturally diverse communities immediately following the September 11 disaster. Connecticut ensured that information and services were available for the recovery community. The State also recruited faith communities to help residents cope with the disaster. New Jersey offered direct outreach and prevention activities to school children in Jersey City—one of the State’s most affected communities because of its proximity to New York City. New York conducted substance abuse-specific outreach, educational forums, professional support groups, and crisis counseling in eight New York City communities that were directly affected by September 11. Virginia met with school staff to address early intervention services for youth and provided funds to school systems to hire additional counselors. The State also provided funds to faith communities to conduct outreach efforts with youth.

Massachusetts undertook several initiatives to reach out to specific cultural groups after September 11. The State conducted mental health and substance abuse outreach to underserved families and a health care provider from the Haitian community in the greater Boston area. The provider placed special emphasis on reaching children who responded adversely to the aftermath of the September 11. The State also assisted in the creation of the Massachusetts Initiative for Multicultural Community to enhance disaster mental health and substance abuse preparedness and to promote mental health services in diverse racial, ethnic, and cultural communities. The group’s first pilot program included nine different racial/ethnic/cultural populations. Finally, Massachusetts sponsored “Project Be Prepared” to address the needs of primary care practitioners working in neighborhood health centers serving ethnic and culturally diverse populations. The group provided health, mental health, and substance abuse education and information-sharing opportunities for practitioners.

Rhode Island conducted specific substance abuse outreach efforts to homeless individuals in rural settings where future disasters are most likely to be weather-related (e.g., hurricanes). The

State awarded a grant to the South Shore Mental Health Center (SSMHC) to assess the substance abuse and mental health case management needs of the rural homeless population. SSMHC assigned both a clinical case manager and outreach case manager to two homeless shelters in rural areas of the State. Rhode Island intends that current collaboration and coordination of community resources between SSMHC and shelters will facilitate interventions, should future services be needed in a disaster.

Providing Various Types of Training

All nine States provided some form of training related to meeting the substance abuse and mental health treatment needs of individuals and communities after September 11. Six States (CT, MA, NJ, NY, RI, VA) provided training to substance abuse and mental health personnel to educate them about disaster response, trauma, crisis counseling, and self-care techniques. Four States (CT, MD, MA, NJ) offered training to groups that collaborated with them in disaster response and service provision following September 11, including hotline staff, faith communities, recovery communities, and interpreters. To evaluate newly created disaster plans, four States (CT, DC, MA, RI) encouraged provider and agency participation in disaster preparedness drills and simulations.

Training for Substance Abuse and Mental Health Personnel

Connecticut administered disaster response trainings to over 2,500 individuals, including the majority of substance abuse prevention and treatment professionals in the State. The State also implemented a trauma-specific training initiative for providers.

Massachusetts revised its crisis counseling training program to include more relevant content on terrorism, substance abuse issues, child and adolescent issues, special populations, and the incident command system. The State trained about 220 staff members to be crisis counselors and added their names to an oncall roster. Massachusetts also developed specialized training for leadership staff of mental health and substance abuse programs. The training focused on issues related to September 11 and covered interventions to address the effects of fear and terrorism and supervision and self-care techniques to address staff stress and vicarious traumatization.

New Jersey offered training to substance abuse provider staff on issues related to the disaster, including the potential for posttraumatic stress disorders among State residents.

New York trained substance abuse prevention and treatment staff to improve their understanding of stress and trauma and the relationship of stress and trauma to substance use and dependence. Provider staff also received training on the early identification of and intervention for individuals at highest risk for initial substance abuse and relapse as a result of September 11.

Rhode Island conducted training in Critical Incident Stress Management for 150 community providers and State employees.

Virginia provided Critical Incident Stress Management training to 150 school and community counselors. The State also offered stress management and skill-building training to substance abuse treatment providers.

Training for Collaborating Groups

Connecticut offered disaster coping and trauma-specific training to persons in recovery. In addition, the State cosponsored a one-day conference for faith-based leaders, “Ministry in Times of Crisis: Integrating Pastoral Care and Behavioral Health Care.”

Maryland trained hotline services staff on the Hotline Online Tracking System (HOTS) developed by the State and the Bureau of Governmental Research at the University of Maryland.

Massachusetts provided training to qualified interpreters on mental health and substance abuse issues that can arise from a disaster event and on the skills needed to assist crisis counselors at a disaster response site.

New Jersey trained hotline staff on potential mental health disorders and substance use resulting from September 11 and on World Trade Center: New Jersey Recovers project procedures.

Emergency Drills and Simulations

Connecticut conducted 13 emergency and disaster simulations to prepare for potential future catastrophic events.

The *District of Columbia* prepared tabletop exercises of emergency scenarios designed to train staff and obtain feedback on the emergency plan.

Massachusetts encouraged substance abuse treatment personnel participation in State and regional drills and exercises for the mainstream emergency management effort.

Rhode Island coordinated community participation in Statewide drills, including a medication dispensing drill to combat a biological attack.

Offering Public Education

Six States (CT, NJ, NY, PA, RI, VA) initiated public education campaigns to raise awareness about potential substance-related reactions to September 11, strategies to cope with disasters, and unhealthy coping behaviors.

Connecticut designed a brochure for the public about positive and negative coping strategies and symptoms of mental and substance use disorders that can occur following a traumatic event. The State also created postcards advertising the 211 help line's services and printed them in English, Spanish, and Vietnamese.

New Jersey produced educational brochures in English and Spanish about the potential effects of disasters and posttraumatic stress disorder.

Pennsylvania created and disseminated brochures on the importance of planning to avoid panic in an emergency and on coping with the stress of disasters.

New York developed educational materials, brochures, posters, and fact sheets designed to make the connection between substance use and the response to a disaster.

Rhode Island produced disaster-related psychoeducational handouts for a variety of populations, including adolescents, parents, teachers, and older adults. The handouts

covered issues related to disaster coping strategies, trauma, grief and loss, and self-care after a disaster occurs.

Virginia developed educational materials for parents, teachers, and teens for coping with disaster and recognizing symptoms of mental health and substance abuse issues.

Common Products

Four States (CT, MD, MA, NY) developed curricula to train substance abuse treatment professionals and collaborating groups on service provision following a disaster. Connecticut designed curriculum guides for two stakeholder groups—recovery communities and health care personnel in the substance abuse and mental health fields. The curriculum for recovering persons addresses trauma and addiction recovery, symptoms of posttraumatic stress disorder, relapse prevention skills, culturally competent services and supports, and the unique contributions that can be made by recovering persons following a community emergency or disaster. The curriculum for substance abuse and mental health providers and agency staff contains information on the impact of disasters, identification of psychosocial concerns after a disaster, psychological trauma and its relationship to substance use issues, and ways to assist individuals and communities following a disaster.

Maryland designed a curriculum to train hotline staff on the Hotline Online Tracking System (HOTS), developed as part of the State's objectives. Massachusetts enhanced a curriculum based on the American Psychological Association's youth violence and suicide video to include information relevant to terrorism. It also trained school personnel on use of the curriculum.

Several States developed disaster preparedness plans as part of their efforts. Three States (CT, DC, MA) discussed their plans in the context of product development. Connecticut's collaboration of public and private emergency response agencies produced a Statewide crisis response plan. The District of Columbia created an *All Hazards Emergency Preparedness Response Plan* that addresses: transportation, communication, information and planning, resource support, health and medical services, law enforcement, media relations and community outreach, and donations and volunteer management. Massachusetts similarly developed a

Statewide *Emergency Management Guide for Human Service Agencies* that includes family disaster planning materials.

Common Lessons Learned

As their projects neared completion, the nine States participating in the September 11 Disaster Relief Grant Program reported a variety of lessons learned and offered advice for other States seeking to develop and implement disaster management activities. States cited the most lessons learned in the area of collaboration and coordination with providers, State agencies, and other stakeholders. They provided additional advice about hotline services, outreach, and training. Common lessons learned and detailed examples from some of the States that cited them are as follows.

1. *Collaborating parties should agree on clearly defined goals and objectives at the inception of a project.*

Connecticut learned the importance of emphasizing provider readiness at the outset of a project so that providers know what will be expected of them (e.g., development of disaster plans).

New York advised that project leadership should reinforce the need for State agencies and substance abuse treatment providers to be part of Federal, State, and local emergency management plans. The ability to bring resources to the effort increases the likelihood of a successful collaboration. In addition, local plans should be developed by substance abuse treatment providers and coordinated with the local emergency management office. Finally, State agencies should not assume that local providers have emergency response plans in place. Some providers may need guidance on how to develop disaster plans.

Maryland and *Pennsylvania* reported that States beginning projects should expect to spend some time navigating and negotiating the different perspectives and concerns of all collaborating agencies and organizations. *Maryland's* project experienced a slow start due to procedural differences between the grantmaking alcohol and drug abuse State agency and the fee-for-service Mental Hygiene Administration. *Pennsylvania* completed a long process to address “turf” issues because of the large number and type of substance

abuse and mental health organizations participating in the collaboration and their various needs and concerns.

2. ***Coordination among public health State agencies must occur before a disaster and is crucial to developing a disaster preparedness plan that can be implemented successfully in the event of a disaster.***

To foster collaboration before a disaster occurs, *Massachusetts* suggested that States provide cross-training opportunities for government agencies, local communities, providers, and consumers for these groups to gain more knowledge about each other's perspectives and activities.

3. ***Diverse, multicultural groups of stakeholders should be involved in disaster response planning efforts.***

Connecticut reported that States must be sensitive to the unique cultural and ethnic groups that they may be called upon to serve in a disaster. Outreach to a specific cultural group must be in the context of that group's norms and values, with special attention to community factors that may impede or facilitate recovery. *Connecticut* also advises that other States include the recovery and faith communities—powerful allies for reaching individuals who may experience significant difficulties as a result of a disaster—in their crisis response and planning activities.

Maryland learned the importance of immediately including first responders in disaster planning because of their first-hand knowledge of what is needed in an emergency.

Rhode Island found that it needed more resources related to cultural and linguistic issues with the Hispanic community. The State recognized a need to include different cultures and languages in its disaster planning efforts.

Virginia recognized that various cultures have different norms related to alcohol and substance use, as well as different responses to emergencies, and that it is important to ensure that disaster preparedness efforts acknowledge, accommodate, and learn from these differences.

- 4. Maintaining the infrastructure developed for disaster preparedness requires continued commitment of the fiscal and human resources to conduct training, recruit new responders, and collaborate with other disaster response agencies.***

One of *New York*'s mottoes was "Planning is Paramount." The State emphasized that funding for emergency planning must fully support the personnel responsible for developing and maintaining disaster response plans which include substance abuse issues.

Pennsylvania and *Rhode Island* agreed that the availability of a staff position to assume responsibility for disaster-related activities is critical, especially in the era of downsized State governments.

- 5. Ongoing training and exercises are required to ensure disaster preparedness among all participating agencies and their personnel.***

New York reported that training attendance and outcomes were better when ongoing training was delivered onsite at substance abuse provider locations, in half-day sessions, and after a disaster. In addition, the State found that charging an initial registration fee, to be refunded at the training, can lower the "no show" rate.

- 6. It is important to prepare for increases in hotline utilization rates that occur several months after a disaster as more people develop and acknowledge substance abuse and/or mental health disorders.***

New York reported that its hotline received more use several months after September 11 than immediately following the disaster.

New Jersey learned that simply changing the name of a hotline from Addiction Hotline to September 11 Hotline resulted in many more calls and the opportunity to assist more people with substance abuse issues. The State also noted that not as many people would admit to an addiction immediately following the disaster as they would several months later.

Virginia stated that its hotline activity increased immediately after the State advertised the hotline through television, radio, liquor stores, and other places in the community. The increased hotline activity was as significant several months after the disaster as it was immediately following the events.

Massachusetts reported receiving many hotline calls from people looking for information and referral options in the months following the disaster as more people became affected by economic difficulties and State budget cuts.

Common Future Directions

Several States have reached the end of their disaster relief grant periods and have determined future directions for their substance abuse disaster preparedness and management efforts, a number of which are common across States. A few States, not yet finished with their grant projects, also shared next steps. Three States (CT, DC, RI) plan to increase or maintain collaborative efforts with local providers and other public health State agencies around disaster preparedness. Rhode Island indicated that it would continue building its substance abuse and mental health disaster response network and develop policies and procedures to ensure effective emergency response.

Four States (CT, DC, NJ, RI) intend to revise training programs and/or curricula for future use by health professionals. Connecticut will revise its curriculum to address substance abuse and mental health cross-training issues. The District of Columbia will continue to conduct simulation exercises to test existing disaster management protocols. New Jersey will restructure its substance abuse treatment network's training program to attract more provider interest. Finally, Rhode Island expects to continue to train its regional response teams in disaster preparedness strategies.

State-Specific Observations from Participating States

As discussed in the previous section, several of the States participating in the Post-September 11 Disaster Relief Grant Program used their funds in similar ways to achieve program goals and objectives for these different activities. The nine States also undertook State-specific activities, developed State-specific products, learned State-specific lessons, or established State-specific future directions. These additional State-specific efforts and lessons learned are the focus of the discussion that follows.

Connecticut

Objectives

To enhance preparedness for future disasters;

To strengthen the disaster response capacity of substance abuse treatment providers;

To develop a crisis response infrastructure, including a plan and education and training;

To address substance abuse needs post-September 11 through specialized services, addiction recovery groups, and public education; and

To formalize linkages with other responders.

Additional State-Specific Activities and Products

Develop the Center for Trauma Response, Recovery and Preparedness (CTRP) to enhance infrastructure development (including curriculum development and training, development of five regional networks of crisis responders, database and Web site development, and disaster plan development);

Establish specialized substance abuse outreach services for culturally diverse recovery communities; and

Create a public education campaign to increase community awareness of potential reactions to September 11 and to provide coping strategies.

Develop Web site (www.ctrp.org) and make some trainings available online;

Disseminate informational inserts in the State's four most widely read newspapers;

Offer treatment provider training available through CTRP's Web site, VHS, and CD-ROM; and

Publish an e-book on coping skills and relapse prevention for the recovery community.

Design the Behavioral Health Regional Crisis Response Information System that contains information on over 350 members of the regional crisis response teams to ensure ongoing

communication with team members, periodic updating of telephone trees, and efficient activation of regional crisis response teams in the event of an emergency;

Create an operations manual; and

Offer continuing education units for trainings in disaster response.

Additional State-Specific Lessons Learned

Provider readiness for service continuity in a disaster will vary, and guidelines for substance abuse service continuity are needed.

Substance abuse issues must be emphasized and discussed more frequently in the context of disaster preparedness training. Substance abuse issues should be more prominent in general public education strategies so that they are considered when a disaster strikes.

A State's disaster response infrastructure can be improved significantly in a short period of time with sufficient dedication of fiscal and human resources. With a strong commitment of resources, Connecticut was able to develop and train a crisis response network in a little over a year.

Little information was available on best practices for substance abuse treatment following a disaster. More research should be undertaken to identify factors that promote resiliency in individuals and communities.

Additional State-Specific Future Directions

Connecticut will build on the work funded through SAMHSA by developing a substance abuse screening tool for use following a disaster. It also will continue to assist providers with the development of emergency management plans.

Connecticut suggests that SAMHSA create a central library of resource materials that can be copied and used during a disaster; create online training materials that can be used by States involved in disaster response planning; catalog model programs and interventions in specific areas of substance abuse and mental health disaster response (e.g., coordination with other disaster responders, self-care techniques); and continue to

provide Federal funding to support efforts to develop and maintain State infrastructures for disaster response.

District of Columbia

Objectives

To provide a framework for the Addiction Prevention and Recovery Administration (APRA) to respond to public emergencies to ensure efficient and effective continuation of services; and

To provide a continuum of care to individuals who have engaged in or increased their illicit drug use as a direct response to September 11.

Additional State-Specific Activities and Products

APRA implemented grant activities in two main areas: agency-wide emergency response planning and expanding services capacity for adolescents.

Commissioned seven studies to identify gaps in existing protocols for disasters;

Established memoranda of understanding with local hospitals regarding methadone distribution in an emergency or disaster;

Established notification telephone trees and protocols for inter- and intra-agency communication in the event of a disaster;

Contracted for six adolescent beds to provide psychiatric testing, consultation, and case management services and expanded residential and outpatient services for adolescents;

Implemented cognitive behavioral therapy and motivational enhancement therapy models in adolescent treatment programs; and

Convened an adolescent council subcommittee to improve the delivery of all substance abuse treatment services to adolescents.

Developed a needs assessment report to disseminate to stakeholders.

Additional State-Specific Lessons Learned

It is important to clearly delineate the roles and responsibilities of critical staff positions (not individual people) in an emergency situation.

When planning for continuation of services in an emergency, it is important to establish guidelines for handling of stockpiled medications, food, and other supplies.

Additional Future Directions

APRA will revise its disaster plan in collaboration with other agencies involved in emergency response.

Maryland

Objectives

To develop a mental health and substance abuse disaster surveillance data collection instrument;

To develop an “electronic notification bulletin board” to send emergency alerts to the hotline staff;

To reduce data collection costs; and

To decrease the time between data collection and analysis.

Additional State-Specific Activities and Products

Standardized business practices of eight different private hotline agencies that contract with the State;

Developed emergency assessment tools for an all-hazards approach;

Captured hotline caller information in real time;

Designed a two-tier tracking alert system that consists of an anonymous information database for the majority of hotline calls and an integrated consent-driven management

information system that allows callers to provide their names and other identifying information for the hotline to make online referrals to service agencies; and

Supported for communication for referral networks between HOTS and ADAA's existing communication and data collection framework.

Created Hotline Online Tracking System (HOTS).

Additional State-Specific Lessons Learned

Maryland advises other States to have in place internal data collection processes. Initially, Maryland contracted with an external company to collect hotline data for three agencies; however, the data were not available to the agencies for six months, and this delay caused many complications.

Additional State-Specific Future Directions

The HOTS application will be implemented in Fall 2004.

Massachusetts

Objectives

To improve the social, emotional, and physical health of students while promoting academic achievement in a safe school and community environment;

To improve the quality of mental health and substance abuse services for students in their schools and communities, and improve access to and utilization of mental health and substance abuse services; and

To improve the school response to preparation for disaster-related substance abuse and mental health needs of students, parents, and school staff.

Additional State-Specific Activities and Products

Developed remote field communication capacity for emergencies;

Enhanced the Parent Advocacy League Statewide network of over 4000 families, professionals, and advocates for children with substance abuse and mental health needs by including information and referrals for disaster mental health and terrorism concerns;

Conducted strengths-based treatment and crisis intervention for children and adolescents in psychiatric inpatient units and secure residential treatment programs;

Participated in the three-day 2002 Massachusetts Emergency Management Agency's Emergency Management Summit for first responders, emergency managers, and public safety personnel and presented a track on disaster mental health and substance abuse services; and

Assisted in the development of a comprehensive Web site entitled "MassSupport."

Additional State-Specific Lessons Learned

When developing a Web site, it is important to anticipate State rules and regulations about the style and content of the site so that the Web site launch does not experience delays. In Massachusetts, the State agency has had to negotiate with the "mass.gov" Web site because everything on the State government Web site must be uniform in appearance. Because of these regulations, the Web site is not operational.

It may be necessary for State agencies to work with personnel to enable them to develop solutions for the community level, as well as the personal level. In Massachusetts, school counselors and other personnel tended to focus on individual student and family issues but experienced difficulty seeing problems on a community level. The State needed to work with them to develop solutions for both levels.

New Jersey

Objectives

To establish a treatment network for individuals directly affected by the attacks;

To increase the proficiency of treatment network providers to serve individuals affected by September 11;

To notify the general public, recovery community, and treatment providers that specialized services are available for those impacted by September 11 through the World Trade Center: New Jersey Recovers project; and

To link an existing addiction hotline to NCADD to ensure that individuals requesting assistance receive direct access to its counselors.

Additional State-Specific Activities and Products

Conducted a conference and ongoing workshops for individuals affected by September 11.

Published newspaper articles on potential effects of September 11 trauma.

Additional State-Specific Lessons Learned

Centralized intake can be a good way to advertise one location that people can go for assistance. However, individual providers need to be able to assess and refer potential clients as well to ensure that there is “no wrong door” for treatment.

When attempting to create community partnerships, it is critical to learn what incentives would encourage groups to be engaged in the goals and activities of the program.

Additional State-Specific Future Directions

New Jersey will continue to structure its treatment system to accommodate expected surges in substance abuse treatment needs in the years following September 11.

New York

Objectives

To provide counseling and assistance to union members and their families who were directly affected by the World Trade Center attacks;

To maintain New York City treatment services immediately following the attacks;

To expand information line hours and add Spanish language capability;

To provide training for local provider staff and New York City Police Department peer officers who provide disaster coping support to fellow officers;

To conduct a Statewide needs assessment; and

To conduct outreach in New York City communities most affected by the attacks.

Additional State-Specific Activities and Products

Provided critical incident debriefing and increased workplace services to union members and their families. Seven performance targets were reached;

Trained 170 union peer counselors;

Provided information and assistance to workers who were unemployed as a result of the World Trade Center disaster;

Provided short-term counseling and referrals to approximately 600 employees;

Secured employee assistance plan services with 30 local unions and 2 employer groups to cover workers, managers, and their families;

Trained over 700 union members on the prevention of occupational injuries and illnesses;

Disseminated articles on prevention and available resources to union newsletters; and

Worked with Group Health Insurance to identify a camp to accept approximately 250 children of victims of the World Trade Center attacks;

Offered approximately 50 separate contracts to treatment providers to ensure continuation of services immediately following September 11. CSAT's funding enabled these providers not only to maintain services but also to handle the increased client flow as a result of September 11; and

Awarded 10 scholarships for substance abuse education for peer support officers who are members of the New York City Police Department.

Conducted literature review on behavioral health needs of communities immediately following disasters.

Additional State-Specific Lessons Learned

Identify efforts requiring longer time commitments (e.g., needs assessment, collaborative planning efforts) and allocate sufficient funds to accomplish these activities.

Expand opportunities for State agency and provider staff to recover after the immediate response period has passed.

Additional State-Specific Future Directions

New York will complete its Statewide needs assessment.

Pennsylvania

Objectives

To support intervention efforts for individuals experiencing trauma and suffering as a direct result of September 11; and

To assist the service delivery system in meeting the treatment needs of clients impacted by the disaster.

Additional State-Specific Activities and Products

Increased the number of Student Assistance Program assessments and referrals; and

Hired a full-time staff member to develop the State's emergency substance abuse and mental health response.

Additional State-Specific Future Directions

Pennsylvania will do the following:

Continue collaborating to develop an "all hazards" disaster plan for both State substance abuse and mental health agencies;

Develop protocols for deployment of qualified and trained responders; and

Develop an incident/disaster response segment in orientation trainings for State agency employees.

Rhode Island

Objectives

To hire a behavioral health disaster preparedness planning consultant to coordinate the department's substance abuse and mental health disaster preparedness efforts, oversee funded projects, and coordinate development and dissemination of resource information to agencies and the general public;

To increase the capacity of primary care physicians to identify and refer individuals with mental health or substance abuse issues;

To respond to treatment/service needs of at-risk populations (e.g., homeless families affected by mental illness or substance abuse) or develop a project creating linkages between schools and community agencies targeting at-risk populations; and

To develop, print, and disseminate disaster-related psychoeducational materials.

Additional State-Specific Activities and Products

Hired part-time coordinator of behavioral health disaster preparedness.

Awarded a grant for the integration of primary and substance abuse and mental health care to The Providence Center (TPC). With this grant, TPC provided onsite substance abuse and mental health services at the Providence Community Health Centers (PCHC) and collaborated with PCHC to implement screening for substance abuse and mental health issues so that primary care providers will recognize symptoms in a disaster.

Additional State-Specific Lessons Learned

States should plan incrementally because they will require the flexibility to change focus, examine existing resources, and redirect funding.

A real disaster is the best teacher—Rhode Island’s greatest lessons were learned while responding to the West Warwick nightclub fire.

The response to a disaster will vary according to the nature of the incident.

The State must identify alternate funding resources to continue work with the TPC demonstration project because third-party reimbursement alone will not be sufficient.

The homeless shelter population responds to and benefits from community support case management services.

A nonintrusive engagement process (e.g., treatment staff onsite at the shelter and at meal services sites) is needed to serve the homeless population successfully.

Additional State-Specific Future Directions

Rhode Island will continue the employment of the part-time disaster response coordinator.

Virginia

Objectives

To provide Critical Incident Stress Management training;

To develop informational materials;

To provide first line referral response for those seeking substance abuse treatment related to September 11;

To assign staff to work with children and families on substance abuse and mental health screening and referrals; and

To develop participatory workshops to address the emotional needs of professional helpers.

Additional State-Specific Activities and Products

Diverted September 11-related substance abuse admissions to local emergency rooms;

Sponsored a Trauma of Survival conference to address needs of professional helpers (e.g., social workers, EMS workers, doctors, nurses, police officers, firefighters, clergy). Several people attended who had served as first responders to the Pentagon attack. The conference included the opportunity for people to do their own risk assessments for posttraumatic stress disorder, mental health issues, substance abuse, and stress management.

Fairfax County used some of its allocated funds to deploy staff members to Arlington County to assist the family members of those who had lost their lives in the Pentagon disaster.

Additional State-Specific Lessons Learned

It is critical to develop a plan that will enable the State to respond more rapidly when a disaster occurs in the community.

Schools should be involved in disaster planning and response efforts.

Identifying ways to address communications issues in the wake of a disaster is essential, because, with fewer local radio stations operational, there are significant problems in exchanging information in a disaster.

Additional State-Specific Future Directions

Virginia plans to add a terrorism operations section to its disaster emergency plan. The State also will maintain its funding resources for addressing terror-related disasters.

Conclusion

Because of SAMHSA's leadership after the events of September 11, States were enabled to improve their ability to respond to emergencies. The nine States participating in CSAT's Post-September 11 State Disaster Relief Grant Program identified important and practical contributions to the substance abuse treatment field they had made during this critical period. Each State approached the challenge differently, but several crosscutting principles arose from their efforts, including the collection of needs assessment data to identify gaps in services; the importance of collaboration with mental health and other State and local agencies, recovery communities, and providers to design disaster plans; provision of outreach and treatment services to diverse groups of individuals and communities directly affected by September 11; the conduct of emergency response trainings and disaster simulation exercises; and production of brochures and fact sheets to educate the public about possible negative impacts of September 11 and healthy coping strategies.

In addition, each State made unique contributions to our understanding of how States can respond to disasters, including reaching consensus about goals, objectives, and major activities at the outset when working collaboratively with other organizations; recruiting culturally diverse individuals and groups for the collaborative to ensure that a wide range of perspectives are considered; providing ongoing training for substance abuse and mental health professionals to maintain disaster preparedness efforts; and preparing for hotline and other service needs to remain in high demand several months following a disaster as more people begin to seek help for substance abuse and mental health issues. State agencies for substance abuse treatment also recognized the importance of collaborating with State mental health agencies to respond better as both substance abuse and mental health problems occurred or were exacerbated following the disaster. The nine participating States responded to tragic events by pioneering new approaches in disaster-related substance abuse treatment services that other States and organizations can use as models and adapt to their needs to expand their own disaster preparedness.

Suggestions for additional technical assistance to build on the work of the current grantees include the following:

Representatives from the five States that conducted needs assessments could be interviewed to determine (1) what the States learned about conducting substance abuse treatment needs assessment; (2) what methods of needs assessment were most and least effective; and (3) what trends were identified across the States in emergent substance abuse treatment needs after a large scale disaster.

Representatives from each of the nine participating States could be interviewed to identify their technical assistance needs with respect to best practices, including best practices for providing services to particular populations (e.g., persons with HIV/AIDS, methadone patients, rural populations, ethnic minorities, women).

Technical assistance regarding the design of future disaster readiness projects, including the development of project timelines, could be provided.

Representatives from each of the participating States could be interviewed to obtain more detailed information about the lessons learned by the CSAT grantees, including information on problems experienced by the States and how the States addressed such problems.

The information gleaned in the process of providing such technical assistance could be synthesized into reports to be shared with Single State Agencies for substance abuse and other stakeholders throughout the country. By supplementing the information already provided by the grantees, these reports can help other States in their efforts to enhance disaster preparedness.